

APPLICATION FOR EMPLOYMENT



Decatur General

1201 Seventh Street, SE
P.O. Box 2239
Decatur, Alabama 35609-2239

(Please print plainly)

Date _____

All information will be treated confidentially. Please answer questions fully; failure to do so will void this application. The use of this application does not indicate there are any positions open, and does not in any way obligate this institution.

PLEASE PRINT YOUR NAME EXACTLY AS SHOWN ON YOUR SOCIAL SECURITY CARD.

NAME Last First Middle Initial

PRESENT ADDRESS No. Street City State Zip Code

TELEPHONE NO. CELL PHONE NO. SOCIAL SECURITY NO.

POSITION(S) APPLIED FOR Rate of Pay expected \$ per hr. or Annual
Rate of Pay expected \$ per hr. or Annual

Do you desire: Full-time Part-time PRN Specify days and/or hours

Were you previously employed by us? If yes, dates: Dept.

List any relatives working for us Name Relationship

Name Relationship

If your application is considered favorably, on what date will you be available for work?

Have you ever been convicted of a felonious crime excluding misdemeanors and summary offenses?

Yes No If yes, describe in full.

Are you a U.S. citizen? Yes No If no, do you have a valid alien work permit? Yes No

Do you have an adequate means of transportation to get to work on time each day? Yes No

Persons to be notified in case of accident or emergency: Name

Street Address City State Zip Code Telephone Number

Are there any special skills or qualifications which you feel would benefit you for work with the hospital?

The Age Discrimination in Employment Act of 1967 prohibits discrimination on the basis of age with respect to individuals who are at least 40 years old.

AN EQUAL OPPORTUNITY EMPLOYER

RECORD OF EDUCATION

	Complete Name and Address of School	Course of Study	Years Attended		Circle Last Year Completed	Did You Graduate?	List Diploma or Degree
			From	To			
High					9 10 11 12	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> GED Yr. _____	
College					1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Specify					1 2 3 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	

PRIOR EXPERIENCE OR TRAINING (CHECK ONLY THOSE AREAS WHICH APPLY)

**Nursing Service
Licensed or Unlicensed**

- Administrative or Supervisory
- ICU/CCU
- I.V. Therapy
- Surgery
- Recovery
- Obstetrics
- Nursery
- E.R.
- Other _____

Service Departments

- Food Service
- Housekeeping
- Maintenance
- Medical Supply
- Other _____

Clerical

- Typing (WPM) _____
- Transcription
- Data Processing
- Accounting
- Medical Records
- Ward Clerk
- Other _____

PROFESSIONAL LICENSES AND CERTIFICATIONS

TYPE	LICENSE NO.	RENEWAL NO.	DATE ISSUED	STATE

PERSONAL REFERENCES (NOT FORMER EMPLOYERS OR RELATIVES)

Name and Occupation	Address	Phone Number

LIST BELOW ALL PRESENT AND PAST EMPLOYMENT, BEGINNING WITH YOUR MOST RECENT.

Name and Address of Company, Type of Business, and Name of Supervisor	From		To		Describe the work you did	Hourly or Annual Starting Salary	Hourly or Annual Last Salary	Reason for Leaving
	Mo.	Yr.	Mo.	Yr.				
Telephone								

If unemployed, give date(s) and brief explanation _____

Name and Address of Company, Type of Business, and Name of Supervisor	From		To		Describe the work you did	Hourly or Annual Starting Salary	Hourly or Annual Last Salary	Reason for Leaving
	Mo.	Yr.	Mo.	Yr.				
Telephone								

If unemployed, give date(s) and brief explanation _____

Name and Address of Company, Type of Business, and Name of Supervisor	From		To		Describe the work you did	Hourly or Annual Starting Salary	Hourly or Annual Last Salary	Reason for Leaving
	Mo.	Yr.	Mo.	Yr.				
Telephone								

If unemployed, give date(s) and brief explanation _____

May we contact the employers listed above? Yes No May we contact present employer? Yes No
 Have you been employed under a different name at any of the above positions? Yes No If yes, explain to enable a check on your work record. _____

CERTIFICATION OF APPLICANT

I understand that the hospital requires certain information about me to evaluate my qualifications for employment and to conduct its business if I become an employee. I understand that false, incomplete or misleading statements on this application or any other hospital documents may be considered sufficient cause for dismissal, if and when discovered. The use of this application does not indicate that there are any positions available and does not act in any way to obligate this hospital. I also understand that the hospital may change the terms and conditions of my employment if necessary and appropriate, that any employment is for an indefinite period of time, that this application (and any other hospital document) is not a contract of employment and that both the hospital and I have the freedom to terminate such employment relationship whenever either chooses to do so for any reason, with or without notice.

SIGNATURE _____ DATE _____

***** **DISCLOSURE AUTHORIZATION** *****

I AUTHORIZE DECATUR GENERAL HOSPITAL TO OBTAIN INFORMATION CONCERNING MY PRIOR EMPLOYMENT.

Signature Date

I DO NOT AUTHORIZE DECATUR GENERAL HOSPITAL PERMISSION TO OBTAIN INFORMATION CONCERNING MY PRIOR EMPLOYMENT.

Signature Date

PERSONNEL USE ONLY

BASE HOURLY RATE _____

UNIT DIFFERENTIAL _____

SHIFT _____

EMPLOYMENT AUTHORIZED BY:

APPROVED BY:
